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The Uses of History in the Unmaking of Modern Suicide

Abstract

This paper explores the notion that the writing of history has played a role in the making of modern suicide, and that it can have its uses in its "unmaking." Examples of the making of modern suicide come from the writings of nineteenth century doctors concerned with formulating new medical truths of suicide, and who came to describe well-known historical "suicides" (e.g., that of Cato) in terms of pathology as part of this project.

The medicalized suicide that was formed in the nineteenth century has come to dominate how the problem is conceptualized and managed. The author's own experiences of working in a community mental health team and his involvement in suicide prevention are drawn on here, and a critique is offered of the "regime of truth" centering on the "compulsory ontology of pathology" that seems to govern so much thinking in this area.

It is argued that the writing of history can provide useful tools when seeking to "denaturalize" particular ways of thinking and acting that have come to be taken as necessary, real, and true. The paper draws on the work of Michel Foucault, and examples are given of how the writing of the history of self-accomplished death can be a form of critique. Histories that seek to map the establishment and circulation of new "truths" of suicide—and the formation of objects, concepts, and subjects in relation to these "truths"—offer possibilities in terms of problematizing unquestioned contemporary assumptions and practices, enabling us "to think against the present."

> … what different forms of rationality present as their necessary condition one can perfectly well do the history of, and recover the network of contingencies from which it has emerged; which does not mean however that these forms of rationality were irrational; it means that they rest on a base of human practice and of human history and since these things have been made, they can, provided one knows how they were made, be unmade.[1]

The Madness of Cato

In November 1839 Forbes Winslow delivered a lecture, "Suicide, Medically Considered," to the Westminster Medical Society.[2] After the talk the debate

Journal of Social History vol. 46 no. 3 (2013), pp. 744–756
doi:10.1093/jsh/shs130

amongst the members focused, for the most part, on the relationship between insanity and suicide, and the death of Cato was often mentioned. At the end of a second evening of discussion, *The Lancet* reported,

> Mr Winslow rose at a late hour to reply: He contended that the object of his paper had been misunderstood and that the main points of it had not been discussed … . With reference to the proof of insanity in some suicides, the case of Cato had been frequently appealed to, but the speakers had taken the view of his character and conduct rather from poetry than history from Addison instead of Plutarch. He contended that the description which the latter gave of the last hours of Cato, fully warranted the opinion that he was a lunatic.[3]

This rather blunt assertion of the madness of Cato is interesting for a number of reasons. Cato had been many things in history up to this point: for Cicero and Plutarch, Cato's self-inflicted death stood out as an exemplary act of model citizenship; for Seneca it was the ultimate act of self-control.[4] In the epic poems of Virgil and Dante, Cato is spared the judgment and punishment of other suicides in the afterlife (in Virgil's *Aeneid* Cato appears as a divinely-ordained lawgiver among the dead).[5] In Dante's *Divine Comedy* Cato appears not in hell (as with other suicides), but instead is shown as the proprietor of Purgatory, and, moreover, on the day of judgment, Dante writes, Cato's body will "shine brightly."[6]

The century before Forbes Winslow's statement on Cato's insanity had seen Thomas Addison's London stage play *Cato* (first performed in 1713). Here, the Roman statesman is presented as a virtuous figure, and his self-inflicted death a courageous act, despite the prevailing belief that deliberate self-killing was a sin and a crime.[7] In eighteenth-century Britain, Cato's death "was the indisputable example of honorable suicide,"[8] and in "French revolutionary culture," writes Irina Paperno:

> Cato's suicide was associated with freedom—understood as political freedom and personal autonomy—with republicanism, and with dignity—understood as control over one's body and one's emotions.[9]

So, given these previous (and at the time, well-known) assessments of his character and the generally positive readings of the manner by which he met his death, Forbes Winslow declaring Cato a lunatic was quite a novel, and interesting, interpretation of his demise.

Medicine, Suicide, and History

Winslow's words can be read as an act of strategic positioning within the debates on suicide in medicine (and more widely) at the time. New claims to truth were being made in relation to suicide; ones drawing on a vocabulary of medicine and science. Cato's self-accomplished death, as exemplary of a certain form of "rational suicide," therefore couldn't be completely ignored (as Winslow himself acknowledged in his *Anatomy of Suicide* book published the following year).[10] For every assertion of the presence of insanity in all cases of suicide (pretty much Winslow's position) there was wont to be a swift rejoinder to the effect, "but what of Cato?" So Winslow responds as he must—Cato was insane. The arguments for Cato's madness were somewhat sketchy (in his *Anatomy* book of 1840 mostly allusions to his impaired intellect, debilitated body, and

lethargic soul), but the force of such statements relied less on supporting empirical evidence, more on an emerging and productive configuration of power-knowledge.

Medical pronouncements on suicide during this period, such as Winslow's, tended to share a commonality of elements, most usually the positing of internal pathology of some description as causative of suicide alongside suggestions for assessing and treating the patient so affected. These could be said to form a particular style of thought in relation to suicide; one intimately connected to the emergence of practices (of confinement, constant watching, and restraint) within an institutional setting (the lunatic asylum).[11] It is this *assemblage* (or "dispositive" in Michel Foucault's term) of discourse, practice, and institution that gives the statements a particular strength or energy. Each of these elements are considerably more visible and dominant with regard to thought, practice and experience in relation to suicide and its prevention in 1840 than half a century before. Medical discourse constituted suicide as an individual, internal, and pathological act, one that therefore required expert knowledge to understand, and specialist medical services to manage and treat.

This position was first set out in detail by French *aliéniste* Jean-Etienne Esquirol. His 1821 article on suicide for the *Dictionnaire des sciences médicales* gave a detailed description of the medical signs and symptoms presented by the suicidal (formulated as arising due to a "pathologie interne"[12]), as well as guidance to their management within the asylum. Forbes Winslow was evidently aware of Esquirol's thoughts on the subject—he acknowledges his assistance in the preface to *Anatomy of Suicide*, and drew on Esquirol's ideas throughout the text. The writings of Falret,[13] Burrows,[14] Pritchard,[15] Ellis,[16] and Mayo[17] are also acknowledged (amongst others) so Winslow's words were part of a wider, and expanding, medical discourse on suicide.

Such a way of conceptualizing acts of suicide was somewhat at odds with competing philosophical, moral, and judicial readings of the issue,[18] and Winslow's statement on Cato (and those of other medical writers on suicide) can also be understood as an act of positioning in relation to these. Whereas Winslow sought to assert medical authority through retrospective diagnosis, Esquirol dealt with "traditional" (non-medical) interpretations of historical suicides such as Cato's (as found, for instance, in the writings of Montaigne, Montesquieu, and Voltaire) by effectively ignoring them, instead proclaiming that what he was studying was entirely new. As Ian Hacking writes, Esquirol was, in his 1821 dictionary entry on suicide:

> … starting an argument to the effect that suicide is a new topic, one that has not been properly examined—and examination will show that suicide is a medical topic. Esquirol lived during one of the great periods of imperial expansion of the profession. He was implying that doctors have the right to guard, treat, control and judge suicides. They are no longer in the domain of moralists and priests, of Augustine and Aquinas. Self-murder has become, he writes, 'one of the most important subjects of clinical medicine.' This is claim-staking with a vengeance.[19]

By Esquirol's reasoning, historians, philosophers, moralists or judges had all lacked the correct knowledge to understand the nature of suicide. New medical truths only now made such acts explicable, and for Esquirol (and other medical

writers) the facts were that "(a) madness was the province of the physician. (b) suicide is a kind of madness. Therefore (c) suicide is in the province of the physician."[20] Winslow, in his pronouncements and writings, argues the same.

It is interesting to think through the consequences of such a position in terms to how the past (as it relates to suicide) can then appear (if at all) within such a scheme. For if suicide is read as invariably an act of insanity, and insanity as an unchanging, transhistorical given, history then becomes strangely ahistorical—past examples of suicide are drawn upon in order to illustrate the unchanging nature of (and relationship between) insanity and suicide. Within the emerging medicalized discourse on suicide (which Esquirol's and Winslow's words could be said to be illustrative, as well as forming part of), contextual factors such as cultural and historical differences become more marginal issues, with madness and suicide taken to be universal, fixed, and central elements. This plays itself out from Esquirol onwards. When medical discourse has encompassed discussion of the past, it has mostly involved:

- pointing to evidence in earlier records, however seemingly distant or remote, of the presence of pathology in suicides (much as with Winslow's comments on Cato, but other, more recent, examples include: a 4000 year old Egyptian poem that is said to reveal that the author was a "severely psychotically depressed man with feelings of persecution and self-deprecation who also undoubtedly shows strong suicidal tendencies";[21] or "[t]he seven sheets of the papyrus … describes an interior landscape not unlike that of almost any lonely, despairing person considering suicide today";[22] another Egyptian poem from roughly the same period "gives a detailed description of negative thoughts, hopelessness and helplessness, which are characteristic of the state of mind of a person contemplating suicide," the "poem presents an accurate picture of depressive mood, and the negative thought pattern that accompanies it," and it is argued that "the Ancient Egyptians appear to have had a significant grasp of the psychopathology of suicide").[23]
- consideration of the ways "pre-scientific" eras didn't quite grasp this truth of the relationship between madness and suicide themselves (although a few writers are said to have come close[24]), and were thus less humane in their responses to its actuality or possibility.[25]
- examination of how the modern medical discovery of this truth of madness in suicide came about.[26]

By dismissing Cato as "a lunatic," Winslow was not only redescribing a well-known suicide in medical terms, but he was also doing interesting things with history—using it to contribute to the "unmaking" of suicide as a moral, philosophical, political or social concern, part of a process of de-contextualization.

Contemporary Thought and Practice in Relation to Suicide

I have argued elsewhere[27] that the emergence and development of this medical/psychiatric style of thought can be read in terms of the formation of a particular "regime of truth" in relation to suicide, one centering on the production and maintenance of a compulsory ontology of pathology. Although other

views (philosophical, moral, and religious) continued to be aired,[28] it is this "thought style," and related practices (confinement, constant watching, restraint), that come to dominate over the next century and more, up until the present. The language has changed so that the issues are now framed in terms of mental illness rather than madness, lunacy or insanity, contributions have been added from other "psy" disciplines beyond psychiatry (psychology, psychoanalysis, and other psychotherapies), and the sites of intervention extended beyond the asylum into numerous community settings (health centers, general hospitals, schools, and prisons). However, the fundamental linkage of suicide to pathology continues to dominate thought, practice, and experience.

Others have noted this trend. Medical ethicist Margaret Pabst Battin has written:

> For much of the twentieth and on into the twenty-first century, thinking about suicide in the West has been normatively monolithic: suicide has come to be seen by the public and particularly by health professionals as primarily a matter of mental illness, perhaps compounded by biochemical factors and social stressors, the sad result of depression or other often treatable disease—a tragedy to be prevented. With the exception of debate over suicide in terminal illness, the only substantive discussions about suicide in current Western culture have concerned whether access to psychotherapy, or improved suicide-prevention programs, or more effective antidepressant medications should form the principal lines of defense.[29]

Battin's statement draws attention to how closed and monologic readings of suicide have become. This particular "regime of truth" has undoubtedly opened up possibilities for understanding and managing self-destructive thoughts, desires, and acts, but, equally, it is also troublesome in terms of its assumptions and effects. An individualized, "internalized," pathologized, de-politicized, and ultimately tragic form of suicide has come to be produced, with, I believe, alternative (and potentially more useful) interpretations of acts of self-accomplished death marginalized or foreclosed.[30]

Understanding of the problem, and strategies for its prevention, have come to be dominated by a style of thought not so far removed from that formulated by Esquirol and Winslow—the belief that all suicides show evidence of pathology. Most usually this is now expressed in terms of a relationship between suicide and mental illness:

> study after study of suicides worldwide has shown that the association between mental illness and suicide is extremely strong, with approximately 90% of those who commit suicide having a diagnosable mental illness.[31]

It is also often stated that it is unethical to place such reasoning anywhere but at the center of thought and practice, with contextual factors at the margins:

> While life events, such as relationship break-ups, significant failures, and financial problems, may contribute to and also influence the timing of suicide, to deny the contribution of mental illness is to neglect a crucial and powerful contributor to suicide.[32]

Elsewhere, Kay Redfield Jamison has put this even more strongly:

> Philosophical views and assumptions about the causation of suicide, while strongly held and necessarily and importantly debated, are not sufficient to disregard the massive and credible medical, psychological, and scientific research literature about suicide. Ignoring the biological and psychopathological causes and treatments of suicidal behavior is clinically and ethically indefensible.[33]

These are forceful statements, and I have found when working with suicidal individuals, providing training and being involved in planning suicide prevention strategies that they produce strong effects in practice. Suicidal individuals themselves are positioned within this discourse of pathology as mentally unwell, and thus not fully responsible for their actions; instead, clinicians are taken to be the responsible, accountable, and possibly culpable agents in relation to their "suicidal patients." Suicide prevention training and planning comes to be largely about the identification and treatment of mental illness within "at risk" populations.

There is an obvious logic to such an approach. If suicide is taken to be strongly associated (probably in a causal relationship) with mental illness, and there is a belief that such illnesses are treatable, then it makes sense to identify those most at risk of falling ill, or those who are ill but un- (or under-) treated. And, once identified, effective treatment can be administered and suicides prevented. It also makes sense, by this logic, to make people aware of the dangers of mental illness in relation to suicide through general health promotion/suicide prevention strategies. Unfortunately, such measures haven't always been as successful as would be expected. Despite a huge increase in the diagnosis and treatment of the illness most often associated with suicide—depression—the "anti-depressant era" has not led to a marked decrease in suicides.[34] Even the dissemination of "expert opinion" through the media would seem to have the unintended and apparently paradoxical effect of increasing the rates of suicide in the period immediately after being aired.[35]

In addition, the dominance of such an approach, and the assumptions embedded within it, are somewhat problematic too. Michael Kral has talked of the "great origin myth" in suicidology—the implicit notion that 'the ultimate origin of suicide, whatever the stressful precursors, lies within the person."[36] This assumption, that self-destructive forces arise primarily from within the "interiority" of the (mentally unwell) individual suicidal subject, has led to the restricted set of readings pointed to by Margaret Pabst Battin.[37] Such an "interiority" is taken to require expert reading (by mental health professionals), who look to find and treat ahistorical and acultural signs and symptoms of illness in the individual. I don't believe that there is anything *in itself* wrong with such an approach, only that the historical and cultural formation of such suicidal subjects cannot be read within such a scheme, and, importantly, the historical and cultural resources potentially able to counteract or resist suicide are seen to be of only marginal importance relative to the identification and treatment of individual mental disorders.

Critical History

So how might history be of use in opening up the topic so that alternative, potentially more useful, understandings of suicide can arise? Criticizing dominant forms of thought can be difficult; strong normative forces can be at work, and the vocabulary and concepts we can draw upon are often more constraining than liberating, arguably because they are so often written through with accepted meanings. The "truths" of suicide (as an act of pathology) are often forcibly set out (Jamison talks of "the *unequivocal* presence of severe psychopathology in those who die by their own hand")[38] and strongly defended (ignoring such facts as "clinically and ethically indefensible").[39]

With this in mind, I argue that history can be utilized to call into question the presumed naturalness, inevitability, and usefulness of such views. In particular the approach taken by Michel Foucault can be of help. Foucault's work[40] concerned itself with mapping the complex relationships between the production, dissemination, and circulation of authoritative knowledge, particular relations of power-to-knowledge and knowledge-to-power, and certain "truth effects" in terms of the constitution of objects and subjects of knowledge. His writings were also forms of critique—they sought to call into question the "taken-for-granted," and to cast light on and challenge the necessity of the "kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest."[41] Analysis of the possibilities for thought and action opened up by particular "truth-telling" practices proceeded alongside with consideration of the ways in which they could be said to be problematic.

For Foucault, historical analysis needed to follow certain principles in order to function as a form of critique. His studies were guided by a consistent anti-essentialism, particularly in relation to questions of human nature—a skepticism towards all "anthropological universals,"[42] indeed to all "universals," was a necessity if history was to have a critical function. When related to suicide, such a history would have to be resistant to grounding its analysis in terms of either an invariant object (that is, the assumption of "essential" or universal features of suicide) or subject (the idea that certain attributes or characteristics are to be found in all suicides and suicidal individuals) of study. In place of the idea of suicide as an unchanging object of study, a critical history would look to establish such an object as an historical and cultural formation. Similarly, the idea of the "constituting" subject would have to be rejected in favor of one taken to be "constituted," or formed in relation to certain historically and culturally specific "regimes of truth." Finally, practices and power relations would be taken to be central to the production of such "regimes of truth," and need to be drawn upon to account for the formation of subjects and objects at particular times and places.

These principles, I believe, allow for an analysis of the "making of modern suicide" that can also act as a critique of contemporary thought, practices, and institutions. A "history of the present" in relation to suicide would highlight the contingencies (indeed, the arbitrariness) involved in its formation as primarily a concern of medicine/psychiatry; it would look to map particular "truth effects" in terms of the objects and subjects produced in relation to authoritative medical scientific knowledge of suicide; and would trace the strategies and

tactics of power employed in the making and maintenance of such a "regime of truth."

There is not the space here to set out detailed descriptions of each of these areas, but the following are summaries of the sorts of arguments that might emerge from such a "critical history":

Contingency

It is possible to argue, for example, that there was nothing necessary or inevitable about the early nineteenth century redescription of suicide as pathological and medical. No empirical evidence presented itself that couldn't be ignored. Physicians initially theorized on the existence of diseased organs (in the viscera) that were said to account for a propensity to suicide. In the absence of validating anatomical evidence in autopsy, speculation focused instead on the brain as the "seat" of suicide, but no consistent findings of abnormality could be found. Talk of diseased and perverted impulses and instincts came to the fore around mid-century, but again, as unobservable phenomena, evidence remained elusive as to their exact location and nature. Shifting categories of illness (suicidal monomania, melancholia, moral insanity) also appear throughout the century, set out in differing relations to suicide, but, as with theories of pathological anatomy and abnormal impulses, the certainty with which they were expressed stood in contrast to their rather limited explanatory powers and practical usefulness.

Truth Effects

By positing a constituted rather than constituting subject it is possible to map the effects of the production and circulation of authoritative knowledge on the formation of subjects—in Foucault's term the connected processes of objectivication and subjectivation.[43]

Medicine (later psychiatric and other "psy" disciplines) discursively constructed suicide as arising due to some form of pathology located within the (physical or mental) interiority of the individual patient (Michael Kral's "great origin myth"[44] in suicidology). This truth of suicide found numerous outlets of expression in the nineteenth century (in medical books and articles, newspaper stories, magazines, coroners' inquests, asylum reports, and case notes, in conversations between staff and consultations with patients, etc.), and through such means came to influence how people thought and acted with regards to suicide.

A process of "subjectivation" (the formation of particular kinds of "suicidal subjectivities") in relation to the production and circulation of authoritative medical and psychiatric knowledge can be traced in nineteenth and early twentieth century records. As an example, the coroners' reports drawn upon in Olive Anderson's *Suicide in Victorian and Edwardian England*,[45] from East Sussex, the City of London and Southwark, provide evidence of the increasing "interior" nature of suicide, of the move away from understanding suicide mostly in terms of socially situated motives and towards seeing suicide as arising from internal, pathological causes. Similarly, the records left by the painter Benjamin Haydon[46] point to how individuals could come to take on board medical ideas

on suicide, and how this could then influence their sense of self and behavior. In his diary Haydon had written:

> … [i]t may be laid down that self-destruction is the physical mode of relieving a diseased brain, because the first impression on a brain diseased, or diseased for a time, is the necessity of this horrid crime. There is no doubt of it.[47]

Haydon believed he was suffering from a "diseased brain" that required relief through bloodletting, and in 1846 he shot himself in the head and then cut his throat. It can of course be argued that Haydon's death was a singular act and therefore unrepresentative of suicides in general at this time,[48] but the fact that Haydon could conceive of self-destruction in terms of pathological anatomy, that the "truth" of his troubles were to be found in medical theories of organic disease that necessitated a drastic physical remedy, points to the formation of new ways of thinking, acting, and experiencing in relation to suffering and suicide.[49]

It can be argued that the "suicide" and "suicidal subjectivities" that come to be formed in relation to medical knowledge are problematic for a number of reasons. The origin of suicide comes to be located within the interiority of the individual subject—a desire to die arising from some form of unseen, internal pathology. For patients, this knowledge can be experienced as disconcerting. Those identified as "suicidal" are positioned as at the mercy of an unpredictable and unknown force, and are taken to require expert help to assess and manage the risk such a force represents in order to keep themselves safe. The continual linkage of mental illness to suicide also opens up the possibility that those diagnosed as mentally unwell will see the emergence of a desire to die as a natural and inevitable outcome of such illnesses.[50]

Strategy and Tactics

Another aim in the writing of a "critical history" can be to call attention to the vested (but often veiled) interests at work in the formation of a "regime of truth." With regards to suicide it could be argued that there was a strategic utility of constituting suicide as pathological for the consolidation and extension of psychiatric (and later "psy") power. The means by which suicide came to be formed as an act of insanity and, concurrently, insanity came to be read as by its nature dangerous can be analyzed as tactical moves which acted to justify asylum practices of confinement, surveillance, and restraint. It also provided the emerging psychiatric profession with a rationale; namely, the protection of individuals and the public from the perceived dangers inherent in madness.[51]

Conclusions

Forbes Winslow's description of Cato as "a lunatic" is illustrative of the way the writing of history could be used to posit the existence of acultural and ahistorical truths of suicide. It is also an example of a particular "style of thought" that emerged and developed during the nineteenth century, one that has come to dominate the topic conceptually and in terms of practice. The "great origin myth" in suicidology[52]—the locating of the source of suicidality within the

pathologized "interiority" of the individual subject—coupled with efforts to establish a "science of suicide," has pushed the field towards efforts to formulate universally applicable psychological and psychiatric theories of suicide at the expense of studying the local and particular.[53] In terms of prevention, the assumptions that inform "the great origin myth" also drive the search for solutions generalizable to any and all "at risk" populations (for instance, the screening for, identification and treatment of depression). A few authors have pointed to the limits of such a stance,[54] but the conceptualization of suicide as a cultural and historical formation remain in short supply, as do prevention approaches that look to harness the resources of communities to understand the operation of, and resistance to, "suicidogenic forces" at a local level.

In order for there to be receptivity to such ideas within suicidology, and for them to be taken up in a meaningful way, it is necessary, I believe, to clear the way a little. It is here that history, or at least Michel Foucault's approach to history, might be useful. In Arnold Davidson's view, Foucault:

> … made use of *history* in such a way as to let us glimpse other possibilities, wrote history so as to free us from the habit of identifying what happens, intellectually and socially, with what must have happened and what must continue to happen … . His recourse to history was meant to show how our forms of rationality depended on human practices, to indicate that these practices were neither necessary nor self-evident, and thus to provide a space to help free us from a sense of fatalism.[55]

Such an approach can, in Nikolas Rose's phrase, help us to "think *against* the present,"[56] so that which has come to seem most necessary, true, and real can be called into question, and the forces and contingencies involved in the formation of our taken-for-granted ways of thinking and acting can be uncovered. Given Foucault's rather mixed reception amongst historians,[57] it perhaps remains rather a moot point as to whether his books should be classified as histories at all,[58] but I do think that if one is looking to understand the making of modern suicide, and wishes to critique the limitations of contemporary thought and practice, an approach that resists placing at its center invariant objects or transhistorical notions of subjectivity (and sees the discursive appearance of such objects and subjects as worthy of comment in itself) undoubtedly has something to offer.[59] But perhaps any good history of the evolution of suicide over time necessarily relativizes the inherent complex issues and thus acts as a counterbalance to the more universalizing tendencies of modern suicidology.

Endnotes

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3. Ibid., 373.

4. Irina Paperno, *Suicide as a Cultural Institution in Dostoevsky's Russia* (Ithaca, 1997), 10.

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6. Alexander Murray, *Suicide in the Middle Ages: The Curse on Self-Murder* Vol 2 (New York, 2000), 310.

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9. Paperno, *Suicide as a Cultural Institution in Dostoevsky's Russia*, 10 note 6.

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24. Robert Burton's *The Anatomy of Melancholy* (first published in 1621) is almost always cited here.

25. See for example: George Rosen, "History," in Seymour Perlin, ed., *A Handbook for the Study of Suicide* (Oxford, 1975), 3–29; and Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide* (New York, 1999).

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29. Margaret Pabst Battin, *Ending Life: Ethics and the Way We Die* (Oxford, 2005), 164.

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33. Kay Redfield Jamison, *Night Falls Fast: Understanding Suicide* (New York, 1999), 255.

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37. Pabst Battin, *Ending Life: Ethics and the Way We Die*, 164 note 33.

38. Jamison, *Night Falls Fast: Understanding Suicide*, 100 note 37.

39. Ibid., 100.

40. For example, see Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. R. Howard (London, 1965), *Discipline and Punish: The Birth of the Prison*, trans. A. M. Sheridan-Smith (London, 1977) and *The History of Sexuality, Volume 1: An Introduction*, R. Hurley trans. (London, 1981).

41. Michel Foucault, *Politics, Philosophy, Culture: Interviews and Other Writings, 1977-1984*, ed. Lawrence Kritzman (London, 1988), 155.

42. Michel Foucault, *Aesthetics, Method, Epistemology* (Essential Works Vol. 2), ed. James D. Faubion (London, 2000), 461.

43. Michel Foucault, *Power* (Essential Works Vol. 3), ed. James D. Faubion (London, 2000), 326–27.

44. Michael Kral "Suicide and the Internalization of Culture: Three Questions," 5 note 40.

45. Anderson, *Suicide in Victorian and Edwardian England*, 171–73.

46. Tom Taylor, *Life of B. R. Haydon, from his Autobiography and Journals*, 3 Volumes, (London, 1853).

47. Ibid., Vol 3, 169.

48. Anderson, *Suicide in Victorian and Edwardian England*, 107 note 48.

49. Marsh, *Suicide: Foucault, History and Truth*, 167 note 2.

50. S. Bennett, C. Coggan, and P. Adams, "Problematizing Depression: Young People, Mental Health and Suicidal Behaviors," *Social Science & Medicine* 57 (2003): 289–99.

51. Marsh, *Suicide: Foucault, History and Truth*, 167 note 2.

52. Michael Kral, "Suicide and the Internalization of Culture: Three Questions," 5 note 40.

53.Michael Kral, "Thomas Joiner, Why People Die By Suicide," *Transcultural Psychiatry* 47 (2010): 515.

54. For example, see Michael Kral, "Suicide and the Internalization of Culture: Three Questions," 221–33 note 40; and Colin Tatz, *Aboriginal Suicide is Different: A Portrait of Life and Self-destruction* (Canberra, 2001).

55. Davidson, *The Emergence of Sexuality: Historical Epistemology and the Formation of Concepts*, 188–89 note 1.

56. Rose, *Inventing Our Selves: Psychology, Power and Personhood*, 18.

57. For example, see Gary Gutting, "Foucault and the History of Madness," in *The Cambridge Companion to Foucault*, ed. G. Gutting (Cambridge, 2003), 47–70.

58. When questioned on this, Foucault once replied: "I am not a professional historian; nobody is perfect." Michel Foucault, comment at the University of Vermont, October 27, 1982, cited by Gutting, "Foucault, and the History of Madness," 49.

59. See Georgina Laragy, "A Peculiar Species of Felony': Suicide, Medicine and the Law in Victorian Britain and Ireland," *Journal of Social History* 46, no. 3 (2013): 732–43; Åsa Jansson, "From Statistics to Diagnostics: Medical Certificates, Melancholia, and 'Suicidal Propensities' in Victorian Psychiatry," *Journal of Social History* 46, no.3 (2013): 716–31; Andreas Bähr, "Between 'Self-Murder' and 'Suicide': The Modern Etymology of Self-Killing," *Journal of Social History* 46, no. 3 (2013): 620–32; and Susan Morrissey, "Mapping Civilization: The Cultural Geography of Suicide Statistics in Russia," *Journal of Social History* 46, no. 3 (2013): 651–67.